

IN THE SPECIFICATION

Please amend the Specification, as follows:

Please amend Paragraph 13, page 3, as follows:

[0013] Figure 7 is a ~~block diagram~~ flow chart of an exemplary embodiment of the method for performing a failure and effects mode analysis of the present invention.

Please amend Paragraph 21, page 5, as follows:

[0021] The step of conducting line talks 28 includes at least a portion of the first entity ~~46~~ 18 arriving on site to the location where the process under review is performed and analyzing site conditions. This also includes interviewing individuals who are associated with the process under review. If the process under review is brand new, a similar process may be analyzed.

Please amend Paragraph 23, page 6, as follows:

[0023] Returning to Figure 1, after completion of the data gathering 12, the first entity 18 identifies the potential failures 14. In this step, the first entity 18 analyzes the gathered data in step 12 and identifies all possible defects that might arise during the process that is under review. These potential failures are listed and then assigned a severity rating. The severity ranking is a standardized ranking system defined by the potential damage from the failure, the cost of the failure in terms of money, and the cost of the failure in terms of time. An exemplary severity chart is provided in Figure 3A and 3B.

Please amend Paragraph 28, page 8, as follows:

[0028] ~~At step 104~~ Next, the first entity 18 performs the first step 12 of the method ~~400~~ 10 and gathers data, including the various inputs shown in Figure 2. Gathering the data will allow the first entity 18 to more effectively and efficiently conduct the failure mode and effects analysis at step 16 with the second entity 20.

Please amend Paragraph 29, pages 8—9, as follows:

[0029] Specifically, reviewing the previous failure mode and effects analyses ~~22~~ 3.0 (22 of Figure 2) includes focusing on finding process controls, including preventive measures (e.g., preventive maintenance, quality checks, inspection), error proofing and mistake proofing devices. These will be documented and retained for use in drafting the failure mode and effects analysis at step ~~44~~ 16. The previous failure mode and effects analysis should also be reviewed for component parts, limited to those that substantially impact the process being analyzed. Previous tasks with high risk priority numbers and especially tasks with high detection ratings should be identified, documented and retained for use in the draft of the failure mode and effects analysis at step ~~44~~ 16. Part design failure mode and effects analysis should also be reviewed to identify high risk priority number items, especially items with high severity ratings. These should be documented and retained for use in the draft of the failure mode and effects analysis ~~at step 44~~ 8.0. Finally, any historical equipment information available from the supplier, such as equipment capability studies and failure mode effects analysis, should be reviewed to identify potential equipment failures. Again, these should be documented and retained for use in the draft of the failure mode and effects analysis at step ~~44~~ 8.0.

Please amend Paragraph 30, page 9, as follows:

[0030] During review of Improved Items 24 of Figure 2, any "What Went Right/What Went Wrong" databases should be reviewed. Solutions that might be used in the process under review should be identified and any solutions that are directly applicable as potential solutions within the process under review should be focused upon. Error proofing and mistake proofing databases should also be reviewed and solutions that are applicable to the process under review should be identified. Any "Lessons Learned" databases should also be reviewed and solutions that may be used in the process under review should be identified. The "Manufacturing Book of Knowledge" or any other guidelines source should be reviewed and any solutions that might be used in the process under review should be identified.

Please amend Paragraph 31, pages 9—10, as follows:

[0031] When analyzing significant differences 26 of Figure 2, differences between the incoming products and any existing products should be reviewed. For example, tighter tolerances or different materials should be identified. Any differences between the process under review and existing processes should be reviewed. The impact of any identified differences on safety, quality, delivery, costs and morale (SQDCM) should be identified and assessed. Examples may include new technology, new process types, different applications for a machine or machine suppliers and new work forces. Any differences between the program supervising the process under review and any previous programs should be reviewed. Any identified differences should be assessed in relation to the impact of these differences on production launch. Examples include: deadlines restricting trials, pilots or testing, late releases and start of the program.

Please amend Paragraph 32, pages 10—11, as follows:

[0032] When conducting line talks 28 of Figure 2, the purpose is to learn what the interviewee knows regarding the process under review or the process that is similar to the process under review. Questions that can be asked include the following: "Have you worked in this station long and do you have a good understanding of what the problems are?"; "Who would you recommend to talk to?"; "What problems have you experienced at this operation?"; "How often do they occur?"; "How easy is it to detect them?"; "Were there any issues at start up?"; "Were there any issues getting the parts out and to measure/verify that there was good quality?"; "Any issues when doing tool changes?"; "Any issues when changing or altering the product/machine or restarting the process after an emergency stop?"; "How do you know you are making a good part?"; "How do you know your machine is working well?"; "Were there any issues remembered from the start of production that had been stalled and what was the solution?" "What error proofing/mistake proofing devices have been installed and do they work well?" Various other questions may be asked and it is not intended that this list be a full and complete example, and the exemplary questions may be used in design or administrative failure mode and effects analysis.

Please amend Paragraph 33, pages 10—11, as follows:

[0033] When reviewing SQDCM results 30 of Figure 2, any relevant parties should be accessed and all safety incidences should be identified. The Plant Environmental Office should be accessed and any site specific environmental concern should be identified. For example, the need for environmental permits should be reviewed and ways to minimize the pollutants covered under the permit should be analyzed. All information regarding warranty defects from the start of the program should be gathered as well as any improvements related to these warranty defects. Warranty defects should be linked with internal defects using discussions with resident/reliability engineers. As this information is gathered and linked, root causes (the physical reason the defect occurred), escape causes (the reason the defect escaped from the station where it was made), and system causes (what allowed the defect to occur and why it was not prevented) should be addressed. Information regarding defects should be gathered from the start of production including the links to internal defects from a tear down vehicle evaluation. Information based on vehicle audits, such as customer satisfaction audits and in-process audits should be gathered. In process audits and repair operations should be reviewed. Repair operations often link test stand defect descriptions to the physical cause of the defect and are therefore very useful. Moreover, in line testing/inspection, audits, off line gauging results, first time capability or first time through, scrap part rates, capability results, gauge reliability and repeatability data, and gauged issues, problems, and frailty should all be reviewed and gathered. Information regarding history of plant on time delivery and capacity analysis should be reviewed, as well as down time tracking including any root causes of

excessive down time events. Cost drivers, such as tooling, lubricant, overtime, and root causes of high costs should also be identified and reviewed. Finally, human resources morale audits for issues regarding working conditions and non-supervisory items should be identified and reviewed.